

## Medical / Dental Coverage Cancellation

*Check all that apply:*

**Medical Coverage:**

- ☐ Retiree
- ☐ Spouse / Domestic Partner
- ☐ Dependant(s)

\_\_\_\_\_  
*Please provide name(s) of dependant(s)*

**Dental Coverage:**

- ☐ Retiree
- ☐ Spouse / Domestic Partner
- ☐ Dependant(s)

\_\_\_\_\_  
*Please provide name(s) of dependant(s)*

I hereby request that the above coverage is cancelled effective \_\_\_\_/\_\_\_\_/\_\_\_\_.

**I understand that by canceling medical and/or dental coverage at this time, I will not have the option of re-enrolling in the group plan.**

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Seattle City Employees' Retirement System**

**801 3<sup>rd</sup> Ave., Suite 300, Seattle, WA, 98104 Telephone: (206)386-1293, Fax: (206)386-1506**

G:\WebForms\Medical Dental Cancellation.doc